

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

acceptable

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 2-story Type II(222), unprotected, non-combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1964 K7 SURVEY UNDER: 2000 EXISTING K8 NF Licensed for 63 beds with a census of 60 on the day of the survey. A Life Safety complaint investigation (TN00029164) was completed on 1/17/12. The facility was cited with Immediate Jeopardy (A situation which the provider's noncompliance has caused, or is likely to cause, serious harm, injury, impairment or death) for tag K38. The Immediate Jeopardy for tag K38 was effective 1/17/12. On 1/17/12 the facility provided corrective action lowering the immediate jeopardy to an "E" level.	K 000			
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-banded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K-018 In order to maintain the doors protecting the corridors, with a positive latch or two sets of fire doors and repair of one doors. The facility has secured the services of a provider on 1-31-2012, who is currently getting specs. The facility will write, 2-2- 2012, for permission from the State of Tennessee to replace these two sets of doors. On 2-2-2012 received proposal for replacement doors. Faxed on 2-3-2012 to State of Tennessee with specs, awaiting approval.	K 018 3-30-12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-89) Previous Versions Obsolete

Event ID: 85CJ21

Facility ID: TN9007

If continuation sheet Page 2 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 025	Continued From page 2 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations, it was determined the facility failed to maintain the smoke barriers. The findings included: 1. Observation of the phone room on 1/17/12 at 6:22 PM, revealed 4 penetrations in the ceiling, walls, and the end of 2 conduits were not sealed. 2. Observation of the kitchen's dish washing room on 1/17/12 at 6:41 PM, revealed a penetration in the ceiling around the hot water pipe. 3. Observation of the kitchen on 1/17/12 at 6:42 PM, revealed a penetration in the ceiling next to the dry storage room. 4. Observation of the kitchen on 1/17/12 at 6:44	K 025	K-025 In order to maintain the smoke barriers The corrective measures below will be put into place: 1. all penetrations have been sealed in the ceiling of the phone room with fire caulking 3 M Fire Block Sealant FB 136 2. the penetrations in the kitchen's dish washing room will be sealed with fire caulking 3M Fire Block Sealant FB 136 3. the penetration in the kitchen ceiling in the dry storage room will be sealed with fire caulking 3M Fire Block Sealant FB 136 4. the conduit sealed at the ceiling above the sink in the kitchen with fire caulking 3M Fire Block Sealant FB 136 5. the conduit above the alarm panel and the metasys copper tube that were not sealed at the wall in the main mechanical room have been sealed with 3M Fire Block Sealant FB 136. K-025 1-27-12		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 025	Continued From page 3 PM, revealed a conduit not sealed at the ceiling above the sink. 5. Observation of the main mechanical room on 1/17/12 at 7:15 PM, revealed a conduit above the alarm panel and the metasys copper tube were not sealed at the wall. These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 025			
K 038 SS=K	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations, testing, and staff interviews it was determined the facility failed to maintain the exit access at all times for three exit doors of eight exit doors used by residents, visitors, and staff in the event of an emergency. The facility's failure to ensure emergency egress placed residents in Immediate Jeopardy (A situation which the provider's noncompliance has caused, or is likely to cause, serious harm, injury, impairment or death). The findings included:	K 038	K-038 To immediately eliminate the Jeopardy the following action was taken and approved: On 1-17-12 the doors were unlocked and were operable through the key pad system. On 1-18-12 the outside key pad was disarmed on all the doors and a sign was placed on the doors "Not An Entrance" A memo was issued to all employees that the doors were unlocked and all exits were obtainable through the key pad system with a sticker to put on their name badge of the code. Keys are now available to all employees in the building from 10:00 P.M. till 5:00 A.M. to override the system should alarm not unlock these doors. A copy of memo and inservice sheet was approved by inspector to verify all employees had been notified. The inside key lock will be dismantled.	K 038 1-18-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	<p>Continued From page 4</p> <p>On 1/17/12 at 5:25 PM, observation of the exit door leading to the exit discharge adjacent to room 107 revealed a magnetic locking system installed on the door with a keypad override. Interview with staff member #1 and licensed practical nurse (LPN) #8 at 5:26 PM, revealed that the staff members were unaware of the code to release the magnetic door lock. Further observations revealed the power to the magnetic door override keypad had the power turned off, requiring a key to switch power back on to the keypad, not allowing exit access at all times. LPN #8 revealed that only the three (3) charge nurses had possession of the keys. At 5:27 PM, LPN #8 retrieved the key and the code and unlocked the door.</p> <p>At 5:44 PM observation of the exit door leading to the exit discharge adjacent to room 109 revealed a magnetic locking system installed on the door with a keypad override. It was discovered the power was shutoff to override keypad not allowing exit access at all times. At 5:45 PM the maintenance director keyed the power back to keypad.</p> <p>AT 5:51 PM observation of the exit door leading to the exit discharge in the vicinity of nurse's station #1 revealed the magnetic locking system installed on the door with a keypad override. It was discovered the power was shut off to override keypad not allowing exit access at all times. At 5:53 PM interview with the maintenance director revealed that the power to the magnetic door lock override keypads on the three (3) exit doors was routinely shut off between 5:00 PM and 6:00 PM each day and reactivated the following morning at approximately 6:00 AM to</p>	K 038			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 038	Continued From page 5 restrict access to resident family members and others that may know the access codes. At 5:54 PM the maintenance director keyed the power back to keypad. All of the exit doors' magnetic locks did release when the fire alarm was activated during the fire drill at 7:54 PM. The Immediate Jeopardy was removed at 5:54 PM on 1/17/12 when the facility provided corrective actions when power was restored to the keypads and the code was provided to all staff members, lowering the scope of the immediate jeopardy to an "E" level.	K 038			
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet 19.2.3.3 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations, it was determined the facility failed to maintain the required exit access width in 1 of the 4 corridors. The findings included: Observations of the corridor located between rooms 103 and 104 on 1/17/12 at 5:10 PM, revealed the corridor was obstructed by a lift and a shower bed. The equipment was stationed on both sides of the corridor reducing the available egress width below four feet.	K 039	K - 039 During the orientation process by the Maintenance Director, new hires will be given instructions on the importance of keeping corridors clear of obstructions. Also with the fire drills the Maintenance Director will include this in this drill, keeping an inservice sheet with signatures of all employees in attendance. Then annual inservices on Life Safety, (done in April and November) conducted by the Maintenance Director, will give all employees written information on the importance of keeping the corridors clear of obstructions at all times. The shower bed was moved on 1-18-2012 and will be stored in the shower room at all times and the lifts were moved on 1-18-2012 and will be stored a different locations at all times getting these two items mentioned out of the hall ways. The LPN charge Nurses will observe as they make their rounds that no obstructions are in the hallways. The Asst. DON will inservice Nursing staff on 2-9-2012 on obstructions.		K 039 2-9-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 039	Continued From page 6 This finding was acknowledged by the administrator during the exit conference on 1/17/12.	K 039			
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on records review, it was determined the facility failed to conduct the required fire drills at least quarterly on each shift. The findings included: Record review on 1/17/12 at 8:32 PM, revealed the facility failed to conduct the required fire during the 3rd shift, 2nd quarter of 2011. This finding was acknowledged by the administrator during the exit conference on 1/17/12.	K 050	K - 050 Fire Drills will be conducted as quarterly required and records will be maintained by the Maintenance Director of those in attendance. Since this one drill can not be accounted for it can not be corrected and the only Plan of Correction is for it not to re occur. Maintenance Director has been told by the Administrator of the importance of having these drills and the importance of keeping up with the documentation.	K 050 1-27-12	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
K 052	Continued From page 7 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations and testing, it was determined the facility failed to maintain the fire alarm system. The findings included: 1. Testing of the main fire alarm panel on 1/17/12 at 7:26 PM, revealed that when phone line # 2 was disconnected from the panel, there were no audible or visual trouble signals received at the main panel, station 3's annunciator panel and at the monitoring station. 2. Observation of the fire alarm annunciator panel located in station 3 on 1/17/12 at 7:31 PM, revealed when phone line 1 was disconnected from the main fire alarm panel there was no audible signal received at annunciator panel. These findings were acknowledged by the	K 052	K- 052 the Provider of service was here on 1-19-2012 and corrected the following: 1. It was verified that the audible was not working on phone line #2 and it was determined a sensor was turned off. It was turned on and now is working. 2. It was also verified that station 3 alarm had no audible signal due to a sensor being turned off. The sensor was turned on and is now working. To prevent this from recurring, the Service Provider will check these sensors with their Quarterly testing.	K 052 1-19-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 052	Continued From page 8 administrator during the exit conference on 1/17/12.	K 052			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations and records review, it was determined the facility failed to maintain the sprinkler system. The findings included: 1. Observation of the main entrance canopy on 1/17/12 at 5:00 PM, revealed the sprinklers were dirty with foreign materials. 2. Observation of residents' room 109 on 1/17/12 at 5:46 PM, revealed paint on the sprinkler located in closet B. 3. Observation of station 1 linen room on 1/17/12 at 5:49 PM, revealed the top shelf was installed within 18 inches of the sprinkler. 4. Observation of the old shower storage room on 1/17/12 at 6:06 PM, revealed the sprinkler was obstructed by a cinder blocks.	K 062	K - 062 The Facility and the Service Provider will put into place the following corrections for the maintenance of the sprinkler system.: 1. The sprinkler heads that were dirty with foreign materials in the main entrance canopy were cleaned on 1-18-2012 2. Provider of Service will replace painted sprinkler head in room 109 closet on 2 - 13-2012 3. The top shelf in the station 1 linen room was removed on 1-18-2012. 4. Provider of Service will install an additional sprinkler head in old shower storage room on 2-13-2012 5. The to check on the clean dish rack in the kitchen has been cleared of anything that would obstruct the 18". The staff have been inserviced by the Dietary Supervisor for the rack to remain clear on 1-20-2012. 6. Provider of Service will perform 5 year obstruction investigation during the week of 2-13-2012.	K062 2-17-12	

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	Continued From page 9 5. Observation of the kitchen's clean dish rack on 1/17/12 at 6:43 PM, revealed storage within 18 inches of the sprinkler. 6. Record review on 1/17/12 at 8:30 PM, revealed the facility failed to provide documentation for the sprinkler system's 5 year obstruction investigation. These findings acknowledged by the administrator during the exit conference on 1/17/12.	K 062			
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Intakes; TN00029164 Based on observations and interviews, it was determined the facility failed to maintain the portable fire extinguishers. The findings included: 1. Observation of the Kitchen on 1/17/12 at 6:31 PM, revealed the K type portable fire extinguisher was blocked with a cart. 2. Interview with kitchen staff member # 1 on 1/17/12 at 6:35 PM, revealed the staff member	K 064	K - 064 The Facility will put into action the following to maintain the portable fire extinguishers: 1. K type portable fire extinguisher is no longer blocked as the cart has been relocated. 2. On 1-30-2012 the staff in the kitchen underwent an inservice on instructions of operating the fire extinguisher in the case of a grease fire. Maintenance Director has signed inservice sheet. The Maintenance Director will place this training with orientation material of new staff personnel for the Kitchen.	K 064 1-30-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 01/17/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

K 064 Continued From page 10
was not trained in which fire extinguisher to use
on a grease fire.

These findings were acknowledged by the
administrator during the exit conference on
1/17/12.

K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Smoking regulations are adopted and include no
less than the following provisions:

(1) Smoking is prohibited in any room, ward, or
compartment where flammable liquids,
combustible gases, or oxygen is used or stored
and in any other hazardous location, and such
area is posted with signs that read NO SMOKING
or with the international symbol for no smoking.

(2) Smoking by patients classified as not
responsible is prohibited, except when under
direct supervision.

(3) Ashtrays of noncombustible material and safe
design are provided in all areas where smoking is
permitted.

(4) Metal containers with self-closing cover
devices into which ashtrays can be emptied are
readily available to all areas where smoking is
permitted. 19.7.4

This STANDARD is not met as evidenced by:
Intakes: TN00029164

K 064

K 066 K - 066 The facility will put into place the
following measure to comply with the
smoking regulations:

1. On 1-27-2012 the Facility ordered from a
Vendor a self-closing device into which
ashtrays can be emptied for the smoking
area located outside station #3's entrance.

2. On 1-27-2012 the Facility ordered from a
vendor a self-closing device into which
ashtrays can be emptied for the smoking
area located in the sun room.

3. On 1-27- and 1-30-2012 the Facility
ordered from a vendor a self-closing device
into which ashtrays can be emptied and
ashtrays for the smoking area located at
station 2's exit. All of the above delivered 2-
2-2012.

A memo dated 2-6-2012 from the
Administrator will instruct the following:
The self-closing ash trays will be emptied
into the self closing devices after each
smoke break of the residents by the escorts
that have taken the residents to smoke at that
particular time. These will be emptied and
cleaned by the Housekeeping staff daily.
The employees will empty their ash trays
into these containers as they fill and the
Housekeeping Department will empty and
clean these devices daily.

K066
2-6-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 066	Continued From page 11 Based on observations and staff interviews, it was determined the facility failed to comply with the required adopted smoking regulations. The findings included: 1. Observation on 1/17/12 at 5:34 PM, revealed the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied readily available at the designated smoking areas located outside station 3's entrance. Interview with staff member #1 revealed the facility failed to provide metal containers with self-closing cover devices into which ashtrays can be emptied readily available at all of the designated smoking areas located outside of the facility. 2. Observation of the residents' designated smoking area located in the sun room on 1/17/12 at 6:45 PM, revealed the facility failed to provide a metal container with a self-closing cover devices into which ashtrays can be emptied readily available. 3. Observation of station 2's exit discharge on 1/17/12 at 6:48 PM, revealed the area was used as a smoking area with no ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied readily available. These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 066			
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply	K 067			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	<p>Continued From page 12</p> <p>with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Intakes: TN00029164</p> <p>Based on observations, it was determined the facility failed to maintain the heating, ventilating, and air conditioning system.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation of residents' room 12 on 1/17/12 at 5:56 PM, revealed the heating and cooling unit's cover was not secured and the unit was not plugged into the electrical outlet. 2. Observation of the of the 12 resident rooms located in station 1 on 1/17/12 at 6:05 PM, revealed the bathrooms' ventilation system was not working. 3. Observation of station 2's housekeeping room on 1/17/12 at 6:52 PM, revealed the ventilation system was not working. 4. Observation of the of the 12 resident rooms located in station 2 on 1/17/12 at 7:01 PM, revealed the bathrooms' ventilation system was not working. <p>These findings were acknowledged by the</p>	K 067	<p>K - 067 the Facility has put into place the following measures to maintain the heating, ventilating and air condition system:</p> <ol style="list-style-type: none"> 1. Room #12's heating and cooling unit's cover will be secured with a removable clamp and the plug will be secured also into the electrical outlet with a preventative cover. 2. Station # bathrooms' ventilation system has been repaired with a new belt and bearings by a Service Provider on 3. Station 2's housekeeping room ventilation is now working. 2-2-2012. 4. Station 2 bathrooms' ventilation system ahs been repaired with a new belt and bearings by a Service Provider on 1-20-2012. <p>To prevent this from reoccurring the Maintenance Director will inspect and document monthly the inspections of the units on the roof for operational status.</p>	<p>K 067 2-10-12</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 067	Continued From page 13 administrator during the exit conference on 1/17/12.	K 067			
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations, interviews, and records review, it was determined the facility failed to protect and maintain the cooking facilities. The findings included: 1. Observation of the kitchen on 1/17/12 at 6:35 PM, revealed there were no instructions for manually operating the kitchen's hood fire extinguishing system posted conspicuously in the kitchen. Interview with kitchen staff member #1 revealed that staff member #1 did not know how to manually operate the kitchen's hood fire extinguishing system. The instructions and shall be reviewed periodically. 2. Observation of the kitchen's hood system on 1/17/12 at 6:37 PM, revealed the fire extinguishing nozzle was not center over the deep fryer. 3. Record review on 1/17/12 at 8:41 PM, revealed no semiannual inspection were conducted on the kitchen's hood fire extinguishing system.	K 069	K - 069 The Facility will put into place the following measures to protect and maintain the cooking facilities: 1. The Maintenance Director will post a conspicuous instruction poster in the kitchen, on 1-31-2012 on how to manually operate the kitchen's hood fire extinguishing system. He also had an inservice on 1- 30-2012 with signed documentation of the training with the current kitchen staff on these instructions and will include it in the orientation of any new hires for the Kitchen. 2. The Provider of service centered the extinguishing nozzle in the center of the deep fryer on 1-20-2012. 3. Attached are semiannual inspections of the kitchen's hood fire extinguishing system. This is semi annual contract with service provider. 4. Attached are semiannual inspections of the kitchen's exhaust hood cleaning. This is a semi annual contract with service provider.	K069 2-2-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 069	Continued From page 14 4. Record review on 1/17/12 at 8:42 PM, revealed the kitchen's exhaust hood cleaning was only conducted once annually. These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 069			
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations, it was determined the facility failed to maintain the means of egress from the exit discharge to the public way. The findings included: 1. Observation of station 2's exit discharge on 1/17/12 at 8:47 PM, revealed the path of egress to the public way was blocked by a concrete bench and table. Further observations revealed the canopy's support column was installed in the path of egress reducing the available egress width below four feet. 2. Observation of station 2's side atrium exit discharge on 1/17/12 at 7:08 PM, revealed grass	K 072	K - 072 The Facility corrected the following means of egress from the exit discharge to the public way: 1. At station 2's exit discharge the concrete bench and table have been moved on 1-31- 2102 and the canopy has been removed on 1-20-2012. 2. The grass that was covering the path of egress to the public way at station 2's atrium exit discharges was removed on 2-1-2012. Also chat was put down and packed to prevent it from returning and prevent slipping.	K072 2-1-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 072	Continued From page 15 was covering the path of egress to the public way. The egress path must be slip resistant. These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 072			
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Intakes: TN00029164 Cylinder and Container Management. NFPA 99, 4-3.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. Penetrations and Miscellaneous Openings in Fire Barriers. NFPA 101, 8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to	K 130	K - 130 With the miscellaneous life safety codes as required that were found to be deficient the Facility will put into place the following measures: 1. In residents room 1 the unsecured oxygen cylinder is now secured. With other residents receiving oxygen therapy these tanks will be secured at all times. The Nursing staff and the Housekeeping staff will daily check for these tanks to be secured. On delivery from the provider of service the Nursing staff will secure the tanks. 2. the penetration in the corridor's fire wall located state 1 side exit doors been filled with 3M fire block FP 136. 3. the penetrations in both sides of the fire wall located between the snack room and lounge have been filled with 3M Fire Block FP 136.	K130 2-9-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 130	<p>Continued From page 16</p> <p>penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:</p> <p>a. The material shall be capable of maintaining the fire resistance of the fire barrier.</p> <p>b. The material shall be protected by an approved device that is designed for the specific purpose.</p> <p>(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the fire barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>Based on observations, it was determined the facility failed to comply with the life safety codes as required.</p> <p>The findings included:</p> <p>1. Observations of residents' room 1 on 1/17/12 at 6:15 PM, revealed one unsecured oxygen cylinder.</p> <p>2. Observation on 1/17/12 at 8:06 PM revealed</p>	K 130			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 130	Continued From page 17 penetrations in the corridor's fire wall located next station 1 side exit door. 3. Observation on 1/17/12 at 8:11 PM revealed penetrations in both sides of the fire wall located between the snack room and lounge. These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 130			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observations it was determined the facility failed to maintain the electrical system. The findings included: 1. Observation of residents' room 106 on 1/17/12 at 5:28 PM, revealed the oxygen concentrator was plugged into an electrical power strip. 2. Observation of residents' room 102 on 1/17/12	K 144	K - 144 In order to maintain the facilities electrical system the facility put into place the following: 1. The power strip in room 106 was removed on 1-17-2012. Maintenance Director and Asst DON will have an inservice to staff to stress the importance of not having these strips for oxygen concentrators. Maintenance Director also did a walk through to see if any other rooms had power strips and will do this with the Housekeeping Department daily. 2. The power strip in room 102 was removed on 1-17-2012. Maintenance Director and Asst. DON will have an inservice to staff to stress the importance of not having these strips for oxygen concentrators. Maintenance Director also		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 18 at 5:30 PM, revealed the oxygen concentrator was plugged into an electrical power strip. 3. Observation of the beauty shop on 1/17/12 at 5:40 PM, revealed the ground fault circuit interrupter located between the sink and the outside wall was damaged. 4. Observation of the kitchen on 1/17/12 at 6:25 PM, revealed electrical panel PNLK had 2 open slots. 5. Observation of the kitchen on 1/17/12 at 6:30 PM, revealed the 3 electrical panels were blocked with equipment. 6. Observation of the kitchen on 1/17/12 at 6:36 PM, revealed the electrical outlet located above the sink was not a ground fault circuit interrupter. 7. Observation of the electrical panel located across room 25 on 1/17/12 at 6:55 PM, revealed an open slot in the panel and the panel was blocked with equipment. 8. Observation of the electrical panel located across room 31 on 1/17/12 at 7:54 PM, revealed the panel was blocked with equipment. 9. Observation of the exit sign located above station 1's fire wall on 1/17/11 at 8:07 PM, revealed the sign's electrical wiring was not installed in a junction box. 10. Observation on 1/17/12 at 8:17 PM, revealed no cover installed on the electrical junction box located above the fire doors next room 27.	K 144	did a walk through to see if any other rooms had power strips and will do this with the Housekeeping Department daily. 3. The ground fault circuit interrupter between sink and outside wall was repaired on 1-20-2012. 4. Facility obtained the service of an electrical provider of service and the electrical panel PNLK's open slots have been filled on 1-31-2012. 5. Of the 3 electrical panels that were blocked with equipment in the kitchen 2 have been unblocked and the 3 rd will require the services of a provider of service to provide a plumbing vendor and will be complete by 2-29-2102. 6. The electrical outlet located above the sink in the kitchen will be repaired with a ground fault circuit interrupter. 7. Facility obtained the service of an electrical provider of service and the open slot in the panel across from room 25 has been filled. The panel itself had been un blocked and the Maintenance Director and the Housekeeping Department will monitor these panels to ensure this deficient practice does not recur. 8. The electrical panel located across room 31 panel has been unblocked and the Maintenance Director and the Housekeeping Department will monitor this panel to ensure this deficient practice does not recur. 9. The electrical wiring for the sign at station 1'2 fire wall will have a junction box installed by our Maintenance Department by 2-29-2012. 03	K144 2-29-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 19 These findings were acknowledged by the administrator during the exit conference on 1/17/12.	K 144	10. A cover was installed on the electrical junction box located above the fire door next to room 27 on 2-1-2012 by our Maintenance Department.	K144 2-29-12	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Intakes: TN00029164 Based on observation, it was determined the facility failed to properly install the alcohol based hand rub dispensers. The findings included: Observation of the main dining room on 1/17/12 at 5:05 PM, revealed the alcohol based hand rub dispenser was installed above the lights on/off	K 211	K- 211 The Facility has removed the alcohol based hand rub dispenser that was above the light on/off switch in the main dining room on 1-18-2012.	K-211 1-18-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44A120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/17/2012
NAME OF PROVIDER OR SUPPLIER JOHN M REED NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 124 JOHN REED HOME RD LIMESTONE, TN 37681		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 211	Continued From page 20 switch. This finding was verified acknowledged by the administrator during the exit conference on 1/17/12.	K 211			